Society for Maternal-Fetal Medicine
High-risk pregnancy experts

SMFM Position Statement

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Society for Maternal-Fetal Medicine Position Statement: Paid family and medical leave

Society for Maternal-Fetal Medicine (SMFM); SMFM Health Policy and Advocacy Committee

Position: The Society for Maternal-Fetal Medicine strongly supports paid family leave and medical leave to optimize the health of pregnant people and their families and to improve health equity. All types of leave should include full wages and benefits and job protection to ensure that parents can care for themselves and their children. The Society for Maternal-Fetal Medicine endorses the implementation of a national policy that would provide fully-paid sick leave in addition to a minimum of 12 weeks of universal paid family and medical leave with job protection to optimize health and well-being across generations.

Key words: equity, maternal health, mental health, prenatal care, quality of life, stress

Background

According to 2022 data, the United States is the only high-income country without paid leave and is 1 of only 7 countries worldwide that do not offer paid leave for birthing parents.[1] Nonetheless, many states, cities, and individual businesses have successfully implemented paid leave policies with both short- and long-term benefits. For example, California was the first state to implement paid leave insurance. Several studies investigating the effect of the policy have shown that it is associated with increased breastfeeding duration,[2] curtailment in child abuse and mistreatment,[3] and reduced likelihood of children experiencing attention-deficit/hyperactivity disorder (ADHD), hearing problems, frequent ear infections, and overweight status.[4] In addition, paid family leave with job protection has been associated with improved pregnancy and maternal health outcomes, including lower rates of preterm birth, decreased rates of infants with low birthweight,[5] improved maternal mental health, and enhanced physical quality of life.[6]

The federal Family and Medical Leave Act (FMLA) provides 12 weeks of unpaid job-protected leave. However, the FMLA only applies to worksites with more than 50 employees and to workers who have been employed for more than 12 months and 1250 hours of service. Therefore, only 56% of US workers are eligible.[7] Of eligible workers who needed but did not use FMLA, 46% cited lack of pay as the reason for not taking leave.[8] In addition, paid leave for birthing persons who experience miscarriage is available to few public and private employees, and there is variability in whether parental leave is available to families after a stillbirth.[9]

Approximately 1 in 4 parents in the US private sector workforce has access to paid family leave through their employer. Although such paid leave access has been steadily increasing in recent years, growth has been confined to high-wage sectors, with relative stagnation among low-wage employees.[10] For example, among workers in the lowest wage decile, only 6% have access to paid leave, compared with 43% of workers in the highest decile.[1,9] Similar disparities are prominent in paid sick leave, which is available to 35% of workers in the lowest decile, compared with 95% of workers in the highest decile.[10] Moreover, paid leave is distributed unevenly by race and ethnicity, with survey data suggesting that 28% of Latina women, 27% of Black women, and only 12% of White women take unpaid time off or leave their jobs to provide care to their families.[7] Thus, increased access to paid leave has the potential to directly improve equity.

The inequities evident in paid leave are particularly striking when examined geographically. All the US states that currently mandate paid family and medical leave laws are states with abortion protections.[11] Thus, in states with restrictive abortion policies, people of reproductive age may not be able to end an unwanted pregnancy and may not have access to paid leave. This creates a considerable financial inequity based on gender.

During pregnancy, the inability to take time away from work or school is a barrier to accessing prenatal care,[12] whereas paid sick leave increases the uptake of preventive care[13] and attendance to well-child visits.[14,15] In addition, paid leave simultaneously reduces emergency department visits for working adults[16] and their children.[17]

Among employed women in the United States, 23% return to work within 10 days after delivery.[8] This early return to work can derail recovery from childbirth, disrupt bonding

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and breastfeeding, and diminish the positive benefits outlined above. This insufficient leave may be especially burdensome for approximately one-third of birthing people in the United States who deliver via cesarean delivery, which is a major abdominal surgery that increases the risk of health complications for both parent and infant. Furthermore, among parents of critically ill newborns, paid leave enables parents to be present at the infant's bedside. Such parental care improves lifelong outcomes: a recent study found that skin-to-skin care in the neonatal intensive care unit improved social and developmental outcomes among high-risk infants at age 20 years.[18]

Parental leave protections are important not only for the birthing person but also for the partner. However, even when offered, fathers often do not take advantage of paid family leave opportunities, potentially because of stigmas and negative stereotypes surrounding leave-taking.[19] "Use-or-lose-it" policies, high wage replacement rates, and dedicated paternal leave time have proven effective in combating low uptake rates among men.[19,20]

Along with the many health benefits associated with paid family leave and sick leave, such policies are also associated with improved employee morale, engagement, and productivity.[21] Despite the many health and economic benefits associated with paid leave, most US families do not have adequate paid leave, and in many cases, families have no paid leave at all. While acknowledging that the potential difficulties of paid medical leave include financial burden on employers, workflow disruption, discrimination in hiring, and abuse of policies, the benefits highlighted in this document must be considered to allow families to bond, recover, and heal without the added stress of returning to work too soon.

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The SMFM recognizes that obstetrical patients have diverse gender identities and is striving to use gender-inclusive language in all of its publications. The SMFM will be using the terms "pregnant person" and "pregnant individual" instead of "pregnant woman" and will use the singular pronoun "they." When describing study populations used in research, the SMFM will use the gender terminology reported by the study investigators.

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